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**The right of everyone to the enjoyment of the highest attainable
standard of physical and mental health**

Report of the Special Rapporteur, Paul Hunt*

* The present document is submitted late so as to include the most up-to-date information possible.

Summary

The present report outlines some of the activities that the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has undertaken since his first interim report to the General Assembly (A/58/427).

In section I, the Special Rapporteur contributes to the tenth anniversary of the International Conference on Population and Development (Cairo, 1994) by considering sexual and reproductive health through the prism of the right to health. At least three of the eight Millennium Development Goals are directly related to sexual and reproductive health. The Special Rapporteur takes the view that the rights to sexual and reproductive health have an indispensable role to play in the struggle against intolerance, gender inequality, HIV/AIDS and poverty, and he recommends that increased attention be devoted to a proper understanding of reproductive health, reproductive rights, sexual health and sexual rights.

In section II, the Special Rapporteur explores the relationship between the right to health and poverty reduction. While Niger's Poverty Reduction Strategy is used as a case study, much of the analysis applies equally to other poverty reduction strategies. The Special Rapporteur argues that the right to health can reinforce and enhance poverty reduction strategies.

Section III provides a brief update on the Special Rapporteur's work regarding neglected diseases and the 10/90 "gap". In accordance with Commission resolution 2003/28, section IV provides some short remarks on the right to health and violence prevention.

CONTENTS

	<i>Paragraphs</i>	<i>Page</i>
Introduction	1 - 6	4
I. THE RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH	7 - 56	5
II. POVERTY AND THE RIGHT TO HEALTH: THE NIGER'S POVERTY REDUCTION STRATEGY	57 - 75	15
III. NEGLECTED DISEASES	76 - 80	19
IV. THE RIGHT TO HEALTH AND VIOLENCE PREVENTION	81 - 86	20
V. CONCLUSION	87 - 89	22

Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health presented his preliminary report to the Commission on Human Rights at its fifty-ninth session in April 2003 (E/CN.4/2003/58). The report outlines the approach the Special Rapporteur proposes to take to his mandate, including basic objectives, main themes and key initiatives to be pursued. In its resolution 2003/28, the Commission on Human Rights took note of the preliminary report with interest and invited the Special Rapporteur to pay particular attention to the linkages between poverty reduction strategies and the right to health, as well as between the realization of this right and aspects of discrimination and stigma. It further asked him to give particular attention to the identification of best practices for the effective operationalization of the right to health. The Commission requested the Special Rapporteur to pursue his analysis of the issues of neglected diseases, including very neglected diseases, and the role of health impact assessments. It asked him to submit an annual report to the Commission on the activities undertaken in the course of his mandate, as well as an interim report to the General Assembly.

Recent activities

2. The Special Rapporteur submitted his first interim report to the General Assembly (A/57/427) in November 2003. The report reflects on the activities of, and issues of particular interest to, the Special Rapporteur in the period since his preliminary report to the Commission. It addresses the issue of right to health indicators which, in the view of the Special Rapporteur, can help States and others recognize when national and international policy adjustments are required. The report also provides an introductory overview of some of the conceptual and other issues arising from right to health good practices. It addresses the Special Rapporteur's concern about the continuing obstacles to ensuring access to prevention and treatment for HIV/AIDS, and it also highlights the need to address the right to health implications of neglected diseases. In its resolution 2003/18, the Commission on Human Rights invited all special rapporteurs whose mandates deal with economic, social and cultural rights to comment on the proposal for an optional protocol to the International Covenant on Economic, Social and Cultural Rights. Accordingly, in his interim report the Special Rapporteur made some observations on this issue.

3. In October 2003, at the invitation of the Canadian Society for International Health (CSIH) and Action Canada for Population and Development (ACPD), the Special Rapporteur attended the Tenth Annual Canadian Conference on International Health, at which he delivered a keynote presentation on "The right to health: new opportunities and challenges". While visiting Canada, the Special Rapporteur attended a series of informal meetings with Ottawa-based officials at the Canadian International Development Agency, the Department of Justice Canada, the Department of Foreign Affairs and International Trade, and Health Canada. Additionally, he met with several civil society organizations in Ottawa and participated in a round table discussion, with non-governmental organizations (NGOs), on the right to health. He also met with representatives of indigenous communities to discuss issues concerning aboriginal health and related policies at federal and provincial levels. The Special Rapporteur is most grateful to all those who organized or participated in these meetings, and especially to CSIH and ACPD for the initial invitation to visit Canada.

4. While in the United States of America to present his interim report to the General Assembly, the Special Rapporteur took the opportunity to meet with World Health Organization (WHO) representatives in New York and representatives of the United Nations Population Fund (UNFPA). He also met with officials working on the Millennium Project, as well as Millennium Development Goal Task Force members. He spoke at a conference, organized by the New York University Center for Human Rights and Global Justice, on human rights and the Millennium Development Goals. The Special Rapporteur travelled to Washington D.C. for meetings at the World Bank to discuss poverty and health issues. In both New York and Washington, the Special Rapporteur met with members of a number of NGOs. Other activities undertaken by the Special Rapporteur during the reporting period are reflected in the report of the Secretary-General on economic, social and cultural rights (E/CN.4/2004/38, paras. 11 and 15).

Individual communications

5. In accordance with resolution 2002/31, paragraph 5 (a), the Special Rapporteur has received information on the right to health from NGOs and individuals. Some of this information has included alleged violations of the right to health. Several of these allegations have related to a lack of access to health care, goods and services for detainees or prisoners. In some cases, State authorities have allegedly denied access to health care for people in detention who were in need of medical assistance. Information has also been received on allegations involving the persecution of health professionals on account of their professional activities; discrimination against particular individuals or groups on the basis of their health status, including HIV/AIDS; non-consensual medical treatment; abusive treatment of mental health patients; and denial of health services for migrant workers. The Special Rapporteur wishes to emphasize that some of the allegations that have been brought to his attention would appear to be extremely serious and highly credible.

6. In the light of resolution 2002/31, paragraph 5 (a)-(d) inclusive, the Special Rapporteur has responded to some of the information received by writing to the Government concerned, either together with other special procedure mandates or independently, inviting comment on the allegation, seeking clarification, reminding the Government of its obligations under international law in relation to the right to health and requesting information, where relevant, on steps being taken by the authorities to redress the situation in question. The Special Rapporteur is grateful for the responses he has received from a few Governments. He urges all Governments to respond promptly to his communications and, in appropriate cases, to take all steps necessary to redress situations involving the violation of the right to health.

I. THE RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH

7. The International Conference on Population and Development (ICPD), held in Cairo in 1994, was a landmark event because participating States recognized that sexual and reproductive health is fundamental to individuals, couples and families, as well as to the social and economic development of communities and nations. The Conference signalled a move away from narrowly focused family planning programmes, placed women at the centre of an integrated approach to reproduction, and recognized that human rights have a crucial role to play in relation to sexual and reproductive health. The following year, this new approach was reaffirmed at the Fourth World Conference on Women held in Beijing.¹

8. As part of his contribution to the tenth anniversary of ICPD, the Special Rapporteur is devoting this section of his report to sexual and reproductive health. These issues are among the most sensitive and controversial in international human rights law, but they are also among the most important. Their sensitivity and importance is reflected in the Millennium Development Goals that derive from the Millennium Declaration. On the one hand, the Goals do not expressly refer to sexual and reproductive health; on the other hand, at least three of the eight Goals - on maternal health, child health and HIV/AIDS - are directly related to sexual and reproductive health.² The Special Rapporteur encourages all actors to recognize explicitly that sexual and reproductive health issues have a vital role to play in the global struggle against poverty.

9. As confirmed by the Commission on Human Rights in 2003, "sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".³ This report explores the implications of this crucial proposition by drawing upon world conference outcomes, in particular ICPD, the Fourth World Conference on Women and their respective five-year reviews, as well as international human rights instruments, including the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child. The following discussion is also informed by the key principles that shape human rights, in particular non-discrimination, equality and privacy, as well as the integrity, autonomy, dignity and well-being of the individual.

10. Not only are sexual and reproductive health issues sensitive, controversial and important, they are also large and complex. The following observations are not comprehensive. The Special Rapporteur hopes, however, that they will contribute to a deeper appreciation of one of the achievements of ICPD: the recognition that human rights have an indispensable role to play in relation to sexual and reproductive health. He also hopes that the following paragraphs will encourage a greater awareness that ICPD, the Fourth World Conference on Women and the United Nations human rights system represent mutually reinforcing norms and processes.

The magnitude of the challenge⁴

11. Sexual and reproductive ill health gives rise to nearly 20 per cent of the global burden of ill health for women and 14 per cent for men. In 2000, an estimated 529,000 women died from pregnancy-related causes, most of which were avoidable; 99 per cent of maternal deaths occur in developing countries. In States in transition and developing countries, more than 120 million couples are not using any contraception despite their wish to avoid or space children. About 80 million women annually experience unintended pregnancies, some 45 million of whom have abortions. Of this number, some 19 million women undergo unsafe abortions, resulting in 68,000 deaths, i.e. 13 per cent of all pregnancy-related deaths.⁵ Apart from mortality, unsafe abortion also gives rise to high rates of morbidity.

12. In addition, 340 million new cases of largely treatable sexually transmitted bacterial infections occur annually. Many are untreated. Millions of mostly incurable viral infections occur each year, including 5 million new HIV infections of which 600,000 are mother-to-child transmissions to infants. Six thousand young people aged 15-24 years become infected with HIV daily. In sub-Saharan Africa and South Asia, about 65 per cent of young people living with HIV/AIDS are female.

13. Of course, not all sexual and reproductive ill health represents a violation of the right to health or other human rights. Ill health constitutes a human rights violation when it arises, in whole or in part, from the failure of a duty-bearer - typically a State - to respect, protect or fulfil a human rights obligation. Obstacles stand between individuals and their enjoyment of sexual and reproductive health. From the human rights perspective, a key question is: are human rights duty-bearers doing all in their power to dismantle these barriers?

14. Many of the numerous obstacles to sexual and reproductive health are interrelated and entrenched. They operate at different levels: clinical care, the level of health systems, and the underlying determinants of health.⁶ In addition to biological factors, social and economic conditions play a significant role in determining women's sexual and reproductive health. The low social status of girls and women frequently contribute to their sexual and reproductive ill health. Many women experience violence during pregnancy, which may give rise to miscarriage, premature labour and low birth weight. Some traditional views about sexuality are obstacles to the provision of sexual and reproductive health services, including reliable information, and these views have an especially damaging impact upon adolescents.⁷ Poverty is associated with inequitable access to both health services and the underlying determinants of health. Too often, improvements in public health services disproportionately benefit those who are better off.

15. Applying human rights to these questions can deepen analysis and help to identify effective, equitable and evidence-based policies to address these complex problems. Crucially, human rights law places obligations on duty-bearers to do all they can to dismantle the barriers to sexual and reproductive health. In relation to sexual and reproductive health, human rights norms have the potential to inform and empower vulnerable individuals and disadvantaged communities. Before considering these issues further in the particular context of the right to health, some observations are required about the approaches of ICPD and the Fourth World Conference on Women to human rights and sexual and reproductive health.

Cairo: some key definitions

16. Adopted by consensus, the International Conference on Population and Development Programme of Action (A/CONF.171/13, chap. I, sect. 1) includes some principles and definitions that were ground-breaking in the context of sexual and reproductive health. They remain highly relevant today.

17. Chapter II confirms 15 principles that guided - and "will continue to" guide - participants at Cairo. Principle 1 begins: "All human beings are born free and equal in dignity and rights." According to principle 8: "Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health." Principle 3 confirms: "The right to development is a universal and inalienable right and an integral part of fundamental human rights." Several other principles refer explicitly to other human rights. In short, the principles provide a human rights framework upon which to construct sexual and reproductive health laws, policies, programmes and projects.⁸

18. Chapter VII - which, significantly, is entitled "Reproductive rights and reproductive health" - is a key chapter. Paragraphs 7.2 and 7.3 are lengthy, but they are so important in the present context that it is necessary to reproduce them:

"7.2. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in the last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."

"7.3. Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning."⁹

19. The following year, the Fourth World Conference on Women adopted, also by consensus, identical provisions in the Beijing Platform for Action (A/CONF.177/20/Rev.1, chap. I, sect. I).¹⁰ In Beijing, however, participants added:

"The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences" (para. 96).

20. The Special Rapporteur will not analyse these provisions in detail but confine himself to three observations arising from the Cairo and Beijing consensus:

(a) In relation to sexual and reproductive health there are a number of interrelated and complementary human rights, such as those set out in paragraphs 7.2 and 7.3 of the ICPD Programme of Action, e.g. “the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice”;

(b) The most encompassing of these rights is the “right to attain the highest standard of sexual and reproductive health”, which also resonates with principle 8;

(c) While there is obviously an intimate relationship between sexual health and reproductive health, ICPD and the Fourth World Conference on Women recognize that sexual health and reproductive health are also different and distinct dimensions of human well-being.

21. In the next section, the Special Rapporteur considers sexual and reproductive health in the context of the right to health and the Cairo and Beijing consensus. However, looking back at ICPD after 10 years, the Special Rapporteur is concerned about some limitations in relation to the definitions adopted. Accordingly, he makes some concluding remarks below on these issues.

Evolving standards and obligations

22. In his preliminary report, the Special Rapporteur outlined the scope of the international right to health by drawing upon existing norms and concepts such as freedoms, entitlements, immediate obligations, international assistance and cooperation (E/CN.4/2003/58, paras. 22 to 36). In the present report, he begins to apply these approaches to sexual and reproductive health in the context of Cairo, Beijing and their respective five-year reviews. As he did in his preliminary report, the Special Rapporteur also draws upon the relevant jurisprudential and policy insights provided by United Nations human rights treaty bodies in the light of their experience examining States parties’ reports over many years.¹¹ He proceeds on the basis that sexual and reproductive health are “integral elements” of the right to health.¹²

23. Inevitably, there is some overlap among the following paragraphs. For example, discrimination features in most sections and, additionally, a separate section is devoted to vulnerability, discrimination and stigma. In the view of the Special Rapporteur, this focus is appropriate because of the widespread and entrenched nature of multidimensional discrimination in the context of sexual and reproductive health.¹³

Freedoms

24. The right to health, including sexual and reproductive health, encompasses both freedoms, such as freedom from discrimination, and entitlements.

25. In the context of sexual and reproductive health, freedoms include a right to control one’s health and body. Rape and other forms of sexual violence, including forced pregnancy, non-consensual contraceptive methods (e.g. forced sterilization and forced abortion), female genital mutilation/cutting (FGM/C), and forced marriage all represent serious breaches of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health.

26. Some cultural practices, including FGM/C, carry a high risk of disability and death. Where the practice exists, States should take appropriate and effective measures to eradicate it and other harmful practices, in accordance with their obligations under the Convention on the Rights of the Child. Early marriage, which disproportionately affects girls, is predominantly found in South Asia and sub-Saharan Africa, where over 50 per cent of girls are married by the age of 18. Among other problems, early marriage is linked to health risks including those arising from premature pregnancy. In the context of adolescent health, States are obliged to set minimum ages for sexual consent and marriage.¹⁴

27. It should be emphasized that although subject to progressive realization and resource constraints, the international right to health imposes various obligations of immediate effect (ibid., para. 27). These immediate obligations include a duty on the State to respect an individual's freedom to control his or her health and body. For example, there is an immediate obligation on a State not to engage in forced sterilization and not to engage in discriminatory practices. In other words, the freedom components of sexual and reproductive health are subject to neither progressive realization nor resource availability.

Entitlements

28. The right to health includes an entitlement to a system of health protection, including health care and the underlying determinants of health, which provides equality of opportunity for people to enjoy the highest attainable level of health.¹⁵ For example, women should have equal access, in law and fact, to information on sexual and reproductive health issues.

29. Thus, States have an obligation to ensure reproductive health and maternal and child health services, including appropriate services for women in connection with pregnancy, granting free services where necessary.¹⁶ More particularly, States should improve a wide range of sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information. The Special Rapporteur urges all duty-holders also to ensure access to such vital health services as voluntary testing, counselling and treatment for sexually transmitted infections, including HIV/AIDS, and breast and reproductive system cancers, as well as infertility treatment.

30. As pointed out in paragraph 11 above, unsafe abortions kill some 68,000 women each year, a right to life and right to health issue of enormous proportions.¹⁷ Women with unwanted pregnancies should be offered reliable information and compassionate counselling, including information on where and when a pregnancy may be terminated legally. Where abortions are legal, they must be safe: public health systems should train and equip health service providers and take other measures to ensure that such abortions are not only safe but accessible.¹⁸ In all cases, women should have access to quality services for the management of complications arising from abortion. Punitive provisions against women who undergo abortions must be removed.

31. Even when resources are scarce, States can achieve major improvements in the sexual and reproductive health of their populations. For example, Sri Lanka has made significant advances over the last decades in relation to sexual and reproductive health by improving education, increasing female literacy, enhancing the quality of health-care services, and making them more available and accessible.¹⁹

Vulnerability, discrimination and stigma

32. International human rights law proscribes discrimination in access to health care and the underlying determinants of health, and to the means for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social or other status that has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health (*ibid.*, paras. 26 and 59-68).

33. Nonetheless, discrimination and stigma continue to pose a serious threat to sexual and reproductive health for many groups, including women, sexual minorities, refugees, people with disabilities, rural communities, indigenous persons, people living with HIV/AIDS, sex workers, and people held in detention. Some individuals suffer discrimination on several grounds e.g. gender, race, poverty and health status (*ibid.*, para. 62).

34. Discrimination based on gender hinders women's ability to protect themselves from HIV infection and to respond to the consequences of HIV infection. The vulnerability of women and girls to HIV and AIDS is compounded by other human rights issues including inadequate access to information, education and services necessary to ensure sexual health; sexual violence; harmful traditional or customary practices affecting the health of women and children (such as early and forced marriage); and lack of legal capacity and equality in areas such as marriage and divorce.

35. Stigma and discrimination associated with HIV/AIDS may also reinforce other prejudices, discrimination and inequalities related to gender and sexuality. The result is that those affected may be reluctant to seek health and social services, information, education and counselling, even when those services are available. This, in turn, contributes to the vulnerability of others to HIV infection.

36. Adolescents and young people under 25 years of age are especially vulnerable in the context of sexual and reproductive health. Adolescence is a period characterized by sexual and reproductive maturation. Yet in many countries adolescents lack access to essential and relevant information and services in relation to sexual and reproductive health. Their need is acute. An estimated 16 per cent of all new HIV infections occur among those under age 15, while 42 per cent of new infections occur among those aged 15-24. Every year there are 100 million new, largely curable, reported cases of sexually transmitted infections among adolescents.

37. In the context of adolescent health, the Special Rapporteur recalls the right of children to "access information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health";²⁰ respect of privacy and confidentiality, including in relation to medical information of adolescents;²¹ and protections against all forms of abuse, neglect, violence and exploitation.²² He also recalls the underlying principles of the Convention on the Rights of the Child, namely the child's right to respect for its survival and development, its best interests and its evolving capacities, as well as the right to non-discrimination, and the importance of involving adolescents in an appropriate manner in developing measures designed for their protection.²³

38. As has been noted, discrimination on the grounds of sexual orientation is impermissible under international human rights law. The legal prohibition of same-sex relations in many countries, in conjunction with a widespread lack of support or protection for sexual minorities against violence and discrimination, impedes the enjoyment of sexual and reproductive health by many people with lesbian, gay, bisexual and transgender identities or conduct.²⁴ Additionally, the Special Rapporteur recalls that the Human Rights Committee, in *Toonen v. Australia*, observed: “Criminalization of homosexual activity ... would appear to run counter to the implementation of effective education programmes in respect of HIV/AIDS prevention.”²⁵

39. Arising from their obligations to combat discrimination, States have a duty to ensure that health information and services are made available to vulnerable groups. For example, they must take steps to empower women to make decisions in relation to their sexual and reproductive health, free of coercion, violence and discrimination. They must take action to redress gender-based violence and ensure that there are sensitive and compassionate services available for the survivors of gender-based violence, including rape and incest. States should ensure that adolescents are able to receive information, including on family planning and contraceptives, the dangers of early pregnancy and the prevention of sexually transmitted infections including HIV/AIDS, as well as appropriate services for sexual and reproductive health. Consistent with *Toonen v. Australia* and numerous other international and national decisions, they should ensure that sexual and other health services are available for men who have sex with men, lesbians, and transsexual and bisexual people. It is also important to ensure that voluntary counselling, testing and treatment of sexually transmitted infections are available for sex workers.

40. Finally, in the context of sexual and reproductive health, breaches of medical confidentiality may occur. Sometimes these breaches, when accompanied by stigmatization, lead to unlawful dismissal from employment, expulsion from families and communities, physical assault and other abuse. Also, a lack of confidentiality may deter individuals from seeking advice and treatment, thereby jeopardizing their health and well-being. Thus, States are obliged to take effective measures to ensure medical confidentiality and privacy.

Available, accessible, acceptable and good quality

41. Analytical frameworks or tools can deepen our understanding of economic, social and cultural rights, including the right to health (ibid., paras. 33-36). One framework that is especially useful in the context of policy-making is that health services, goods and facilities, including the underlying determinants of health, shall be available, accessible, acceptable and of good quality. This analytical framework encompasses sexual and reproductive health. For example, sexual and reproductive health services, goods and facilities must be: available in adequate numbers within the jurisdiction of a State; accessible geographically, economically (i.e. be affordable) and without discrimination; culturally acceptable to, for example, minorities and indigenous peoples, as well as sensitive to gender and life-cycle requirements, and respectful of confidentiality; and scientifically and medically appropriate and of good quality.

42. When this framework is applied to sexual and reproductive health, it is clear that the key elements of availability, accessibility and so on are frequently absent. For example, in many countries, information on sexual and reproductive health is not readily available and, if it is, it is not accessible to all, in particular women and adolescents. Sexual and reproductive health services are often geographically inaccessible to communities living in rural areas. These

services are sometimes not provided in a form that is culturally acceptable to indigenous peoples and other non-dominant groups. Lastly, services, and relevant underlying determinants of health, such as education, are often of substandard quality.

Respect, protect and fulfil

43. Another useful analytical framework is that States have specific obligations under international law to respect, protect and fulfil the right to health (ibid., para. 35). While the framework outlined in the preceding paragraphs (availability, etc.) is especially helpful in the context of policy-making, the respect, protect and fulfil framework is especially useful as a way of sharpening legal analysis of the right to health, including sexual and reproductive health.

44. The obligation to respect requires States to refrain from denying or limiting equal access for all persons to sexual and reproductive health services, as well as the underlying determinants of sexual and reproductive health. For example, it requires them to refrain from denying the right to decide on the number and spacing of children. The obligation to protect means that States should take steps to prevent third parties from jeopardizing the sexual and reproductive health of others, including through sexual violence and harmful cultural practices. For example, countries such as Burkina Faso, Ghana, Senegal and the United Kingdom of Great Britain and Northern Ireland, have enacted laws that specifically prohibit female genital cutting. The obligation to fulfil requires States to give recognition to the right to health, including sexual and reproductive health, in national political and legal systems. Health systems should provide for sexual and reproductive health services for all, including in rural areas, and States should carry out information campaigns to combat, for example, HIV/AIDS, harmful traditional practices and domestic violence.

International assistance and cooperation

45. In addition to obligations at the domestic level, developed States have a responsibility to provide international assistance and cooperation to ensure the realization of economic, social and cultural rights in low-income countries. This responsibility arises from recent world conferences, including the Millennium Summit, as well as provisions of international human rights law.²⁶

46. Thus, States should respect the right to health in other countries, ensure that their actions as members of international organizations take due account of the right to health, and that they pay particular attention to helping other States give effect to minimum essential levels of health. The donor community provides important funding for sexual and reproductive health care in many low-income countries. The Special Rapporteur urges those countries providing assistance to adopt a rights-based approach to their policies and programmes. For example, their funding should promote access to a wide range of services needed for the enjoyment of the right to sexual and reproductive health, including services and information that reduce the incidence of unsafe abortions.

47. Increasingly, bilateral and multilateral donors are providing health-budget - rather than project-specific - support. Broadly speaking, the Special Rapporteur welcomes such sector-wide approaches. However, it is of the first importance that sexual and reproductive health not be marginalized in a sectoral approach. There is a high risk of marginalization because of the

sensitivities associated with some sexual and reproductive health issues. It is for this reason that the Special Rapporteur urges all actors, despite the sensitivities, to recognize explicitly the indispensable role of sexual and reproductive health in the struggle against poverty. Explicit recognition is important because what is unnamed is more likely to be unsupported.

Conclusion

48. The right to health requires that health policies, programmes and projects are participatory. The active and informed participation of all stakeholders can broaden consensus and a sense of “ownership”, promote collaboration and increase the chances of success. Since sexual and reproductive health are integral elements of the right to health, it follows that all initiatives for the promotion and protection of sexual and reproductive health must be formulated, implemented and monitored in a participatory manner.

49. The right to health also demands accountability. Without mechanisms of accountability, the obligations arising from the right to health are unlikely to be fully respected. This applies equally to the integral elements of sexual and reproductive health. Thus, all initiatives for the promotion and protection of sexual and reproductive health must include effective, accessible and transparent mechanisms of accountability in relation to all duty-bearers.

Concluding remarks: Cairo+10

50. In the preceding section, the Special Rapporteur considered sexual and reproductive health in the light of the right to health and the consensus adopted at Cairo and Beijing. As the Special Rapporteur has observed, the Cairo conference was a landmark event with notable achievements. However, as part of the 10-year review, it is timely to examine ICPD critically. It is in that context that the Special Rapporteur makes the following observations.²⁷

51. First, the two conferences confirmed that:

(a) Numerous human rights have a direct bearing upon sexual and reproductive health,²⁸

(b) There are “reproductive rights”;²⁹

(c) There is a “right to attain the highest standard of sexual and reproductive health”;³⁰

(d) Sexual health and reproductive health are intimately related, but distinct, dimensions of human well-being.³¹

52. Second, while they recognized sexual health as distinct from reproductive health, they did not explicitly and unequivocally recognize sexual rights as distinct from reproductive rights.³²

53. Third, they provided a short definition of sexual health: “the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases”.³³ A fuller definition of sexual health is a state of physical, emotional, mental and social well-being related to sexuality, not merely the absence of disease, dysfunction

or infirmity; sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

54. Fourth, sexuality is a characteristic of all human beings. It is a fundamental aspect of an individual's identity. It helps to define who a person is. The Special Rapporteur notes the abiding principles that have shaped international human rights law since 1945, including privacy, equality, and the integrity, autonomy, dignity and well-being of the individual. The Special Rapporteur also notes the points made in paragraph 51 above, all of which have been widely accepted by the international community. In these circumstances, the Special Rapporteur has no doubt that the correct understanding of fundamental human rights principles, as well as existing human rights norms, leads ineluctably to the recognition of sexual rights as human rights. Sexual rights include the right of all persons to express their sexual orientation, with due regard for the well-being and rights of others, without fear of persecution, denial of liberty or social interference.

55. Fifth, the Special Rapporteur recommends that increased attention be devoted to a proper understanding of sexual health and sexual rights, as well as reproductive health and reproductive rights.³⁴ The contents of sexual rights, the right to sexual health and the right to reproductive health need further attention, as do the relationships between them. Since many expressions of sexuality are non-reproductive, it is misguided to subsume sexual rights, including the right to sexual health, under reproductive rights and reproductive health. Given the nature of his mandate, the Special Rapporteur has a particular concern with the rights to sexual and reproductive health, hence the title of this section of the report. These rights, however, have to be understood in a broader human rights context that includes sexual rights.

56. Finally, considered together, the rights to sexual and reproductive health have an indispensable role to play in the struggle against intolerance, gender inequality, HIV/AIDS and global poverty.

II. POVERTY AND THE RIGHT TO HEALTH: THE NIGER'S POVERTY REDUCTION STRATEGY

57. In his preliminary report to the Commission the Special Rapporteur identifies some particular projects that he would like to undertake, including an examination of poverty reduction strategies through the prism of the right to health. The report emphasizes that he will only undertake these projects so far as "resources and opportunities" permit. The Commission, in resolution 2003/28, invited the Special Rapporteur "to pay particular attention to the linkages between poverty reduction strategies and the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

58. In 2002, the Government of the Niger prepared its full Poverty Reduction Strategy (PRS) in the context of the Heavily Indebted Poor Countries Initiative.³⁵ In June 2003, the Government organized a Forum in Niamey to promote external support for its PRS. Representatives of the Office of the United Nations High Commissioner for Human Rights attended this meeting which, according to reports received by the Special Rapporteur, was both well organized and

successful. To its credit, the Government of the Niger recognizes that human rights have an essential role to play in its struggle against poverty, a view that was expressly confirmed by the Prime Minister in his opening remarks to the Forum.

59. The Special Rapporteur took the opportunity presented by the Forum to prepare some preliminary comments, from the point of view of the right to health, on some of the health-related aspects of the PRS. On an informal basis, these brief comments were circulated among participants. The Special Rapporteur understands that his comments were welcomed by participants, including representatives of the Government.

60. Given the Commission's invitation to consider these issues, the Special Rapporteur wishes to make some remarks about poverty reduction strategies and the right to health. His remarks refer to the PRS and draw upon the comments that were distributed at the Forum.³⁶ The remarks are not comprehensive, but illustrative. Also, they are made on the basis of only a desk review of the PRS: the Special Rapporteur has neither visited the Niger, nor discussed the PRS with health professionals familiar with the Niger. Nonetheless, the Special Rapporteur suggests that it is possible to have a more constructive discussion about poverty reduction strategies and the right to health, in line with resolution 2003/28, if the discussion takes place in the context of a particular PRS.

61. In the Special Rapporteur's opinion, Niger's PRS is one of the best in francophone Africa. It has numerous features that, in the context of human rights generally and the right to health in particular, are commendable, including the following:

(a) The objective of the Strategy "to improve the overall level of ... health of the population, to broaden the access of communities, in particular rural ones, to safe water ... and to improve the quality of life of both urban and rural populations" (3.1); this reflects, *inter alia*, that the right to health extends beyond health care to encompass the underlying determinants of health, such as access to safe drinking water;

(b) The intention of the Government to initiate a strategic planning process in relation to HIV/AIDS as a first step towards implementation of a national strategic plan (4.2.3.3.2); this reflects one of the most important contemporary right to health issues: the HIV/AIDS pandemic;

(c) The objective of increasing the availability of essential drugs (5.3.2.1.1) and ensuring that essential, high-quality medicines are available at affordable prices (3.3.3.2.viii); this reflects, *inter alia*, that access to essential drugs is an integral component of the right to health.

62. Since these features reflect the international obligations of Niger with respect to the right to health, two observations are appropriate. First, an explicit reference in the PRS to these obligations would reinforce a number of the Strategy's objectives. Second, the growing body of international human rights law and practice can help to identify the specific interventions (e.g. policies and programmes) that are needed to achieve several of the Strategy's goals.

63. The following are five other illustrative issues from the PRS that merit further attention from the perspective of the right to health.

Vulnerable groups

64. Human rights - and the right to health - have a particular concern about those who are disadvantaged, marginal and living in poverty. This preoccupation is reflected in numerous human rights provisions, such as those relating to non-discrimination and equal treatment. Experience suggests that general interventions designed for the whole population - or even interventions designed for those living in poverty - do not always benefit the most vulnerable and marginal. While Niger should be commended for identifying some vulnerable groups, such as women and children, in its PRS, it does not appear to acknowledge and address the particular health access issues of all marginal groups, such as the Niger's different ethnic or racial groups. Thus, further attention could usefully be given to the right to health of all vulnerable groups, including specific ethnic or racial groups, such as the country's nomadic populations. Particular health interventions for specific vulnerable groups will probably be needed.

Affordable essential drugs

65. According to the right to health, a State has an obligation to make essential drugs both available and accessible within its jurisdiction. Accessibility has a number of dimensions, including economic accessibility. Obviously, there is limited merit in a State ensuring that an essential drug is available within its jurisdiction if the drug is so expensive that only the rich can obtain it.

66. According to the PRS: "Essential drugs and vaccines will be made regularly available and accessible in health centres, as a result of a new drug pricing policy based on an analysis of costs and health-care payment capacity of the poor. At the same time, a sustainable cost recovery system will be established ... With respect to cost recovery, a new pricing policy will be put in place following an analysis of the actual capacity and willingness of consumers of health services to pay for health care. Following a feasibility study, a health insurance scheme will be implemented on a pilot basis" (5.2.2.1.2).

67. This quotation raises a number of crucial right to health issues. The reference to "a feasibility study" is to be welcomed: this study should include an assessment of the likely impact of the new scheme on the enjoyment of the right to health of those living in poverty. It is unclear whether user-fees will be charged and, if so, whether those living in poverty will be exempt or will receive other assistance to enable them to benefit from essential drugs. As the PRS is implemented, these issues will need careful attention.

Public health education and information

68. The right to health includes access to health-related education and information. From the point of view of the right to health, a pro-poor health policy should include education and information campaigns concerning the main health problems in local communities, including methods of prevention and control. As the PRS is reviewed, this element of the right to health deserves due attention.

International assistance and cooperation

69. In his previous reports, the Special Rapporteur remarks on the human rights concept of international assistance and cooperation which can be traced from the Universal Declaration of Human Rights, through to binding human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child, and which resonates with recent world conference outcomes, including the Millennium Declaration.³⁷

70. The enormous scale of the health problem confronting the Niger is relevant to the human rights concept of international assistance and cooperation. The PRS acknowledges the Niger's "alarming health situation with a mostly illiterate population; a constantly deteriorating environment with an impoverished economy" (4.2.3.3.3.). It remarks that the Niger has "provided the private sector with every opportunity to play the lead role, namely in the areas of production and commercial activities. Unfortunately, it is not yet dynamic enough to take over" (4.1.3.4). Significantly, it observes that two of the health-related Millennium Development Goals - reduction of maternal mortality by three quarters and reduction of child mortality by two thirds - "seem unrealistic for Niger" (3.3.3.2). In other words, it is clear from the PRS that Niger will not be able to realize even the minimum essential levels of the right to health in the foreseeable future without very considerable and sustained international assistance and cooperation. In 2002, the Joint Staff Assessment of the International Monetary Fund and the World Bank endorsed the PRS and concluded: "the current gaps in implementation capacity will require that external partners step up their technical assistance support in line with PRSP priorities" (para. 34).

71. Of course, this does not divest the Government of the Niger of its responsibility to do everything in its power to realize the right to health for all those in its jurisdiction. Clearly, the Government could do more to promote the right to health. For example, between 1994 and 2000 the Government earmarked only 6 per cent of its budget for health, well below the 10 per cent recommended by WHO (1.2.2.3.5). However, the point is that, as reflected in international human rights law and the Millennium Declaration, both the Government and its bilateral and multilateral partners have responsibilities in relation to the right to health in the Niger.

72. As the PRS puts it: "Development partners share equal responsibility with Niger authorities for achieving the ambitious goals set by the Millennium Declaration" (4.1.3.5). In these circumstances, it would seem appropriate for the PRS to refer not only to the Millennium Declaration, but also the human rights concept of international assistance and cooperation. It is on the basis of such a normative framework that a realistic, balanced and equitable sector-wide approach to health in the Niger can be constructed.

Monitoring and accountability

73. The right to health introduces globally legitimized norms or standards from which obligations or responsibilities arise. These obligations have to be monitored and those responsible held to account. Without monitoring and accountability, the norms and obligations are likely to become empty promises. Accountability mechanisms provide rights-holders (e.g. individuals) with an opportunity to understand how duty-bearers have discharged their obligations, and it also provides duty-bearers (e.g. ministers and officials) with an opportunity to explain their conduct. In this way, accountability mechanisms help to identify when - and what -

policy adjustments are necessary. Accountability tends to encourage the most effective use of limited resources, as well as a sense of shared responsibility among all parties. Transparent, effective and accessible accountability mechanisms are among the most crucial features of a human rights - and a right to health - approach to poverty reduction.

74. The PRS candidly acknowledges that its monitoring and evaluation mechanisms need strengthening (p. 11 and para. 6.1). Importantly, monitoring and accountability mechanisms are needed in relation to both national actors (e.g. Government) and international actors (e.g. bilateral and multilateral partners). Moreover, these mechanisms should be developed with the active participation of stakeholders, including those living in poverty, to help ensure that they are accessible, transparent and effective.

Conclusion

75. The Special Rapporteur suggests that the relevance of these observations is not confined to the Niger. As this discussion has tended to confirm, a right to health approach to poverty reduction does not imply a radically new approach; rather, it is likely to reinforce and enhance elements existing in many anti-poverty strategies. In the opinion of the Special Rapporteur, the integration of the right to health into poverty reduction strategies is one of the most important issues arising from his mandate. The general contribution of human rights to poverty reduction - equality, non-discrimination, participation, accountability and so on - is reasonably clear.³⁸ Now the pressing challenge is to clarify, on the basis of reliable evidence, the specific contribution of the right to health to poverty reduction. The Special Rapporteur remains keen to contribute to this challenging task, so far as his resources and opportunities permit.

III. NEGLECTED DISEASES

76. A recent WHO publication describes neglected diseases as those diseases that “affect almost exclusively poor and powerless people living in rural parts of low-income countries”.³⁹ They include Chagas’ disease, sleeping sickness and river blindness. In his preliminary report, the Special Rapporteur argues that “neglected diseases, very neglected diseases and the 10/90 disequilibrium are human rights issues.”⁴⁰ Subsequently, the Commission requested him to pursue an analysis of neglected diseases. In his report to the General Assembly, the Special Rapporteur explained how he had begun to take this issue forward (A/58/427, paras. 76-80). The Assembly’s subsequent resolution on the right to health included a paragraph on “diseases causing a heavy burden in developing countries”.⁴¹ In the present report, the Special Rapporteur will not repeat what was set out in his earlier reports. Instead, he wishes to bring the Commission up to date on two developments regarding his work and neglected diseases, and to make one other observation.

77. First, in December 2003 the Special Rapporteur was invited to participate in the International Workshop on Intensified Control of Neglected Diseases convened by WHO, the German Federal Ministry of Health and Social Security (with the Robert Koch Institute, Berlin), the German Agency for Technical Cooperation and the United Nations Development Programme/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR). Participants included a wide range of actors, including developing and developed States, international organizations, pharmaceutical companies, academics and NGOs. The Special Rapporteur presented a paper with some preliminary and brief reflections on the

right to health - and human rights - dimensions of neglected diseases.⁴² He found the meeting very fruitful and was encouraged by the response to his preliminary reflections, and is grateful to the organizers for the opportunity to participate in this event.

78. Second, in his report to the General Assembly the Special Rapporteur observed that he was meeting with TDR. He is pleased to confirm that TDR has recently agreed to provide him with modest financial support to enable him to obtain research assistance for a few weeks on the human rights dimensions of neglected diseases. This will enable him to deepen his human rights analysis of neglected diseases and report to the next session of the Commission and/or Assembly.

79. Briefly, one of the human rights dimensions of neglected diseases that the Special Rapporteur wishes to explore concerns international assistance and cooperation. International cooperation is needed to promote the development of new drugs, vaccines and diagnostic tools for diseases causing a heavy burden in developing countries. Additionally, however, there is a need to make existing drugs for neglected diseases more accessible to those impoverished populations that need them. The problem is not only one of neglected diseases; it is also an issue of neglected populations.

80. In that context, the Special Rapporteur takes this opportunity to welcome a recent Canadian initiative that may improve access to drugs in low-income countries. Following the decision of the World Trade Organization (WTO) on 30 August 2003 that countries producing generic copies of patented drugs under compulsory licence may now export drugs to countries with no or little manufacturing capacity, the Government of Canada introduced a bill into Parliament to amend the Patent Act and the Food and Drugs Act. If enacted, this initiative should make it easier for Canadian companies to produce, and developing countries to import, generic drugs at lower cost. This is an example of how a developed country can help to improve access to medicines in poor countries, thereby honouring its human rights responsibilities of international assistance and cooperation. The Special Rapporteur hopes that any amendments that might be made to the Canadian legislation fully reflect the spirit and scope of the Doha Declaration on the Trade Related Aspects of Intellectual Property Rights Agreement and Public Health, as well as Canada's concurrent human rights responsibilities. The Special Rapporteur encourages all WTO member States to make use of the full range of flexibilities available under international trade law to promote the right to health in developing countries.

IV. THE RIGHT TO HEALTH AND VIOLENCE PREVENTION

81. The following paragraphs are a brief response to resolution 2003/28 in which the Commission invited all relevant special rapporteurs to report on the issue of violence prevention. The Special Rapporteur already addresses issues relating to violence and the right to health by responding to compelling information he receives from NGOs.⁴³ Also, the section in this report on the rights to sexual and reproductive health includes some reflections on violence. The present section contains a few preliminary observations on the relationship between the right to health and violence prevention.⁴⁴

82. The links between human rights and violence prevention are well established. A lack of respect for human rights is often the root cause of violence, while specific acts of violence may themselves amount to a violation of human rights. Introducing a human rights approach to

violence prevention brings to bear States' international obligations concerning risk factors for violence such as poverty, gender discrimination, lack of equal access to education, and other social and economic inequalities. At the same time, violence is increasingly recognized as a global public health problem. The WHO "World Report on Violence and Health", for example, highlights the importance of measuring violence in terms of its impact on health outcomes around the world, recognizing and addressing the underlying causes and risk factors for violence and reducing its consequences. Only recently, however, have public health and human rights approaches been conceived as complementary and mutually reinforcing contributions to the prevention of violence.⁴⁵

83. To be effective and sustainable, violence prevention requires an appreciation of the synergies between these two approaches. As a first conceptual step, this requires defining violence in terms of both its health consequences and its human rights implications. The WHO report characterizes violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."⁴⁶ By focusing broadly on violence as it relates to the health of individuals, and including outcomes beyond those that result in physical injury or death, this definition reflects an appreciation of the full impact of violence on the right to health of individuals, families and communities.

84. According to this definition, violence clearly has a direct impact on the enjoyment of the human right to health of those affected. It often results in significant physical, psychological and emotional harm to individual victims and contributes to social problems for individuals, families and communities. Indirect costs of violence such as medical expenses related to injuries, costs related to legal services, policing and incarceration, and lost earnings and decreased productivity may further impede the full realization of the right to health, as well as other related rights. These costs place an additional strain on scarce resources and may hinder the development of health systems.

85. States' international obligations to respect, protect and fulfil the right to health can have an important bearing on violence prevention efforts. The obligation to protect, for example, includes an obligation to take measures to protect vulnerable or marginalized groups, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. This involves integrating a gender perspective into health-related policies, planning, programmes and research in order to promote better health for women and men. The duty to fulfil includes an obligation to provide information campaigns about domestic violence, as well as accessible, good quality services for those needing treatment. States have an obligation to ensure that all relevant health personnel receive appropriate training so they can deal sensitively with the issues arising from violence.

86. These brief reflections tend to confirm that the right to health has an important role to play throughout the development and implementation of violence prevention policies. In his country missions, the Special Rapporteur will give particular attention to domestic violence in the context of the right to health.

V. CONCLUSION

87. Throughout his work, the Special Rapporteur emphasizes the importance of a “policy approach” to the right to health, i.e. bringing the right to health to bear upon local, national and international policy-making processes. In this report, he has begun to explore what such an approach means, especially in relation to sexual and reproductive health, and poverty reduction.

88. The right to health - like all human rights - brings a set of globally agreed norms or standards, which give rise to governmental obligations in relation to which effective and transparent monitoring and accountability mechanisms are required. This combination of globally legitimized norms, obligations, monitoring and accountability empowers disadvantaged and marginalized individuals and communities. Policies that are based on human rights norms, including the right to health, are more likely to be effective, robust, sustainable, inclusive, equitable and meaningful for all members of society.

89. The Special Rapporteur encourages all Governments to integrate the right to health in an explicit and comprehensive way throughout their activities, as a means of reinforcing and enhancing their ongoing policies, strategies and programmes.

Notes

¹ The new approach was reaffirmed at the respective five-year follow-up review conferences.

² Other Millennium Development Goals concern the underlying determinants of health, e.g. those on extreme poverty and gender equality.

³ Commission on Human Rights resolution 2003/28, preamble and para. 6.

⁴ For various reasons, sexual and reproductive ill health is severely underestimated and so statistics fail to capture the full burden of such ill health. Nonetheless, data give some indications of the magnitude of the problem.

⁵ An unsafe abortion is a procedure for terminating an unwanted pregnancy performed either by persons lacking the necessary skills, or in an environment lacking the minimal medical standards, or both.

⁶ Examples of the underlying determinants of health are indicated in E/CN.4/2003/58, para. 23. In summary, they are social, economic and other conditions that bear upon health status, such as access to adequate sanitation, workplace conditions and education.

⁷ See *Making 1 Billion Count: Investing in Adolescents' Health and Rights*, UNFPA, 2003.

⁸ For one way in which the framework could be strengthened, see paragraph 54 of this report.

⁹ Paragraph 7.3 continues with some important sentences which have not been reproduced here because of the shortage of space.

¹⁰ Paragraphs 7.2 and 7.3 of the ICPD Programme of Action are replicated in paragraphs 94 and 95 of the Beijing Platform for Action.

¹¹ In particular, the Committee on the Elimination of Discrimination against Women, general recommendation 24, the Committee on the Rights of the Child, general comments No. 3 and No. 4, and the Committee on Economic, Social and Cultural Rights, general comment No. 14.

¹² Commission on Human Rights resolution 2003/28.

¹³ Also, one of the Rapporteur's twin themes is discrimination and stigma: see E/CN.4/2003/58, para. 41.

¹⁴ Committee on the Rights of the Child, general comment No. 4 on adolescent health and development, paras. 9 and 19.

¹⁵ E/CN.4/2003/58, para. 23. On underlying determinants of health, see endnote 6.

¹⁶ In relation to free services and pregnancy, see in particular the Committee on the Elimination of Discrimination against Women, art. 12.2.

¹⁷ Unsafe abortion also gives rise to high rates of morbidity.

¹⁸ *Safe Abortion: Technical and Policy Guidance for Health Systems*, World Health Organization, 2003.

¹⁹ Women's Health in South Asia, WHO Country Profile, Sri Lanka, available at <http://w3.whosea.org/nhd/pdf/61-64.pdf>.

²⁰ Convention on the Rights of the Child, art. 17.

²¹ Ibid., art. 16 and the Committee on the Rights of the Child, general comment No. 4, para. 11.

²² Ibid., arts. 19, 32-36 and art. 38.

²³ Convention on the Rights of the Child, arts. 2, 3, 5, 6, 12. Also Committee on the Rights of the Child, general comment No. 4, para. 12.

²⁴ Other special rapporteurs have documented violence and discrimination based on sexual orientation. See, for example, report of the Special Rapporteur on extrajudicial, arbitrary or summary executions, Ms. Asma Jahangir (E/CN.4/2001/9), paras. 48-50 and report of the Special Rapporteur on the question of torture (A/56/156), paras. 17-25.

²⁵ Human Rights Committee, *Toonen v. Australia*, 4 April 1994, (CCPR/C/50/D/488/1992), para. 8.5.

²⁶ See E/CN.4/2003/58, para. 28 and A/58/427, paras. 30-34.

- ²⁷ Of course, these observations relate to very few of the many issues in ICPD.
- ²⁸ Cairo Programme of Action, ICPD 7.3.
- ²⁹ Ibid., chapter VII.
- ³⁰ Ibid., para. 7.3.
- ³¹ Ibid., para. 7.2.
- ³² Although note paragraph 96 of the Beijing Platform for Action.
- ³³ Cairo Programme of Action, para. 7.2, the Beijing Platform for Action, para. 94.
- ³⁴ There is growing academic literature on this subject. An excellent place to start is Rebecca Cook, Bernard Dickens and Mahmoud Fathalla, *Reproductive Rights and Human Rights: Integrating Medicine, Ethics, and Law*, Clarendon Press, 2003. On sexual rights, see Alice Miller, "Sexual but not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights", *Health and Human Rights: An International Journal*, vol. 4, No. 2, pp. 69-109.
- ³⁵ Government of the Niger: Full Poverty Reduction Strategy, Niamey, January 2002, available online at http://poverty.worldbank.org/files/9355_NigerPRSP.pdf.
- ³⁶ The Government of the Niger has agreed that the Special Rapporteur, in this report, may draw upon his remarks to the Forum of June 2003. The Special Rapporteur is very grateful to the Government for its approval and wishes to emphasize that he has sole responsibility for these observations, which reflect his views as an independent expert.
- ³⁷ E/CN.4/2003/58, para. 28, and A/58/427, paras. 32-36.
- ³⁸ See, for example, the *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies* prepared by the Office of the United Nations High Commissioner for Human Rights in September 2002, following a request from the Committee on Economic, Social and Cultural Rights.
- ³⁹ WHO, *Global Defence against the Infectious Disease Threat*, 2002, p. 96.
- ⁴⁰ E/CN.4/2003/58, para. 81. The 10/90 disequilibrium, or gap, refers to the fact that only about 10 per cent of health research and development is directed to the health problems of 90 per cent of the world's population.
- ⁴¹ General Assembly, resolution 58/173, para. 13.
- ⁴² This paper, entitled *Neglected Diseases, Social Justice and Human Rights: Some Preliminary Observations*, is available online at <http://www.who.int/hhr/news/en/>.

⁴³ See paragraphs 5 and 6 of this report.

⁴⁴ The *World Report on Violence and Health* (WHO, 2002) classifies violence into three main categories: “collective violence”, “self-directed violence” and “interpersonal violence”. The Special Rapporteur intends to address issues related to the right to health and armed conflict in future reports; for the purposes of this brief section, he confines his comments to self-directed and interpersonal violence.

⁴⁵ For a useful volume on the links between violence, health and human rights, see *Health and Human Rights: An International Journal*, vol. 6, No. 2, 2003.

⁴⁶ *World Report on Violence and Health* (WHO, 2002), p. 5.
